BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of New Rule I, the amendment of ARM 37.79.102, 37.79.201, 37.79.206, 37.79.207, 37.79.209, 37.79.301, 37.79.302, 37.79.303, 37.79.312, 37.79.316, 37.79.326, 37.79.501, 37.79.503, 37.79.505, 37.79.601, 37.79.602, 37.79.605, 37.79.606, 37.79.607, and 37.79.801, and the repeal of ARM 37.79.504 pertaining to the Children's Health Insurance Program (CHIP)	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, AND REPEAL

TO: All Interested Persons

1. On November 14, 2007, at 1:00 p.m., the Department of Public Health and Human Services will hold a public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana, to consider the proposed adoption, amendment, and repeal of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process (including reasonable accommodations at the hearing site) or who need an alternative accessible format of this notice. If you need an accommodation, contact the department no later than 5:00 p.m. on November 5, 2007. Please contact Rhonda Lesofski, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena MT 59604-4210; telephone (406)444-4094; fax (406)444-1970; e-mail dphhslegal@mt.gov.

3. The rule as proposed to be adopted provides as follows:

RULE I ELECTRONIC APPLICATIONS AND SIGNATURES (1) The CHIP program will accept electronic applications and signatures. Electronic signatures are allowed in compliance with the requirements of ARM Title 30, chapter 18, subchapters 106, 117, and 122 to the extent those provisions are not inconsistent with this subchapter.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

4. The rules as proposed to be amended provide as follows. New matter is underlined. Matter to be deleted is interlined.

37.79.102 DEFINITIONS As used in this subchapter, unless expressly provided otherwise, the following definitions apply:

(1) remains the same.

(2) "Ambulance services" means all mileage, services, procedures, and supplies provided by a licensed ambulance provider.

(2) remains the same but is renumbered (3).

~~(3)~~ (4) "Benefits" means the services an enrollee is eligible for as outlined in this subchapter. All benefits ~~with the exception of dental and eyeglass services,~~ are provided to an enrollee through the ~~insurer~~ department.

(4) through (6) remain the same but are renumbered (5) through (7).

~~(7)~~ (8) "Earned income" means ~~income received from employment, self-employment activity, profession, vocation or pastime and includes wages, salaries, tips, commissions, profits, farm or ranch income and honoraria~~ payments received as compensation for work performed. Some examples are: bonus, wages, salaries, tips, commission, self-employment, military pay, and severance pay.

(8) through (8)(c) remain the same but are renumbered (9) through (9)(c).

~~(9)~~ (10) "Enrollee" means an individual who is eligible to receive CHIP benefits as determined by the department under this subchapter and is enrolled ~~with an insurer~~ in the CHIP program. An individual is not an enrollee while on a waiting list or pending issuance of a hearing decision or during any period a hearing officer determines the individual was not eligible for CHIP benefits. The term "enrollee" and "member" are synonymous.

(10) remains the same but is renumbered (11).

~~(11) "Family" means a group of individuals who are residing together as a single economic unit. Members of the economic unit are considered to live together even though a member may reside temporarily in a residential treatment setting. For purposes of this subchapter, a minor living alone shall be considered an economic unit.~~

(12) "Family span" means the 12 month period ~~of eligibility~~ beginning the first day of the month after an ~~applicant qualifies~~ eligibility determination for CHIP benefits is completed and ending the last day of the 12th month. Although qualified for CHIP benefits, applicants placed on the waiting list may not be enrolled during the entire family span.

(13) "Federal poverty level (FPL)" means the poverty income guidelines ~~for 2003~~ published in the Federal Register by the U.S. Department of Health and Human Services for 2007.

(14) and (15) remain the same.

(16) "Income" or "family income" means the ~~adjusted~~ gross earned income~~, as defined by federal tax law and regulations plus~~ unearned income and imputed income of the custodial parent ~~of the family as defined in this rule~~. Regular, continuing, and intermittent sources of income will be annualized for purposes of determining the annual income level. ~~Family income does not include:~~

~~(a) earned income of individuals in the household who are under 19 years of age, unless they are of school age and are not attending school;~~

~~(b) money received from assets drawn down such as withdrawals from a savings account, an annuity or from the sale of a house or a car;~~

~~(c) gifts, loans, one-time insurance payments, or compensation for an injury;~~

~~(d) per capita income to enrolled members of Native American tribes;~~

~~(e) earned income which is excluded and dependent care expenses which are deducted from income under the state Medicaid poverty programs for children; or~~

~~(f) income excluded under federal Medicaid regulations.~~

(17) remains the same.

~~(18) "Insurer" means an authorized insurer, health service corporation or health maintenance organization (HMO) with a valid certificate of authority issued by the Montana commissioner of insurance to transact business in the state of Montana.~~

(19) and (20) remain the same but are renumbered (18) and (19).

(20) "Member" means an individual who is eligible to receive CHIP benefits as determined by the department under this and is enrolled in the CHIP program. An individual is not a member while on a waiting list or pending issuance of a hearing decision or during any period a hearing officer determines the individual was not eligible for CHIP benefits. The term "member" and "enrollee" are synonymous.

(21) through (23) remain the same.

~~(24) "Premium" means the amount of money the department pays monthly to an insurer for the provision of benefits for each enrollee. The premium is paid whether or not the enrollee received covered benefits during the month for which the premium is intended. All benefits outlined in this subchapter, except eyeglass and dental benefits, are covered through payment of this premium.~~

~~(25) "Primary care provider" means a participating health care professional designated by the insurer to supervise, coordinate or provide initial care or continuing care to a CHIP enrollee and who may be required by the insurer to initiate a referral for specialty care and to maintain supervision of health care services to the CHIP enrollee.~~

(26) remains the same but is renumbered (24).

(25) "Serious emotional disturbance (SED)" means a designation determined by qualified department staff and based on social history and clinical information in the form of a psychological assessment with DSM-IV diagnosis, completed by a licensed psychologist, social worker, or professional counselor, that a youth is seriously emotionally disturbed according to the definition set forth in ARM 37.86.3702(2).

(27) remains the same but is renumbered (26).

(27) "Third party administrator (TPA)" means an entity with a certificate of registration to conduct business in Montana in accordance with 33-17-603, MCA. The CHIP program may contract for TPA services including but not limited to claims processing, maintaining an adequate network of participating providers, coordination and continuation of care, health education, notices, quality assurance, reporting, case management services, and customer service.

(28) "Unearned income" means ~~income that is not defined as earned under this subchapter and includes interest, dividends, distributions from trusts or estates, social security benefits, veteran's benefits or payments, workers' compensation and unemployment compensation benefits. Unearned income does not include income excluded under federal Medicaid regulations~~ all payments received other than earned income. Some examples are: adoption subsidies, annuities, dividends,

interest, social security benefits, disability, and unemployment insurance payments.

(29) "Waiting list" means a list of applicants who have been determined eligible for CHIP but who are not enrolled because funds are not available ~~to pay their health care premiums~~.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.201 ELIGIBILITY (1) An applicant may be eligible for covered services under CHIP if:

(a) and (b) remain the same.

(c) the family of which the applicant is a member has annual family income, without regard to other family resources, at or below ~~150%~~ 175% of the ~~2003~~ federal poverty level (FPL);

(d) through (g) remain the same.

(h) the applicant does not have or has not had creditable health insurance coverage as defined in 42 USC 300gg(c) ~~during the three months~~ 30 days prior to ~~applying~~ becoming eligible for CHIP. This ~~three month waiting~~ 30 day period shall not apply if the parent or guardian providing the insurance:

(i) dies;

(ii) is fired or laid off;

(iii) can no longer work due to a disability;

(iv) has a lapse in insurance coverage due to new employment; or

(v) has an employer who does not offer dependent coverage.

(i) and (j) remain the same.

(2) Family ~~i~~income information for all family members must be included on the signed and dated application.

(a) Family income includes:

(i) the income of both parents if the child resides with both parents;

(ii) the income of the custodial parent, including any child support received for the child, if the child resides with one parent in a single parent household:

(A) If the custodial parent has remarried, the stepparent's income is imputed to the custodial parent.

(B) The income of individuals under the age of 19 who live in the household but do not attend school is inputted to the custodial parent.

(b) Family income does not include:

(i) money received from assets drawn down such as withdrawals from a savings account, an annuity, or from the sale of a house or a car;

(ii) gifts, loans, one-time insurance payments, or compensation for an injury;

(iii) the first $2,000 of an enrolled tribal member's per capita payment;

(iv) the first $2,000 of an enrolled tribal member's tribal land income;

(v) the interest earned on (2)(b)(iv) and (v);

(vi) earned income which is excluded and dependent care expenses which are deducted from income under the state Medicaid poverty programs for children;

(vii) income excluded under federal Medicaid regulations;

(viii) foster care income for any children unless the only children in the family are in foster care; or

(ix) income of an individual with whom a child resides who has no legal obligation to support the child.

(a) and (b) remain the same but are renumbered (c) and (d).

(3) An applicant whose CHIP enrollment ended because his or her parent was activated into military service and who was insured through Tri-care, which is the insurance available to active duty and retired military families during the parent's military activation period, is not subject to the ~~three month~~ 30 day waiting period for previous creditable health insurance and will be enrolled in CHIP if he or she continues to be eligible for CHIP. Upon notification that the parent was deactivated and the applicant loses Tri-care coverage, the applicant may be re-enrolled:

(a) through (4) remain the same.

(5) Applicants who are losing Medicaid coverage or who were denied Medicaid for a reason other than the family withdrew their application or failed to comply with Medicaid requirements will be referred to CHIP via an electronic report. CHIP eligibility will be determined and applicants will be enrolled in CHIP or placed on the CHIP waiting list.

~~(a) Applicants will be mailed a form to authorize the use and disclosure of health information that will include questions about the family's health insurance and whether health insurance is available to the family.~~

(6) Applicants and their parents or guardians must comply with the procedures specified by ~~the insurer or~~ the department ~~or both~~ as necessary to obtain or access benefits.

(7) CHIP benefits do not start until the applicant is enrolled ~~with the insurer~~ even though the applicant may have been determined eligible for CHIP prior to the date of enrollment.

(8) CHIP eligibility is redetermined within one year after the initial eligibility period, and annually thereafter. A renewal application must be completed, signed, dated, and returned by a specified date for purposes of eligibility redetermination. Prior eligibility for CHIP does not guarantee continued eligibility ~~nor~~ or enrollment ~~with an insurer~~ in CHIP.

(9) and (10) remain the same.

AUTH: 53-4-1004, 53-4-1009, MCA
IMP: 53-4-1003, 53-4-1004, MCA

37.79.206 ELIGIBILITY REDETERMINATION, NOTICE OF CHANGES

(1) through (2) remain the same.

(3) A CHIP renewal application must be completed and CHIP eligibility redetermined every 12 months. If the renewal application is not returned before CHIP enrollment is scheduled to end, benefits will terminate. A new application may be completed at a later date but, if the children are determined eligible, they ~~the applicant~~ may be placed on the waiting list if one exists.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.207 TERMINATION OF ELIGIBILITY AND GUARDIAN LIABILITY

(1) through (1)(b) remain the same.

(2) CHIP eligibility terminates at the end of the month the department becomes aware:

(a) and (b) remain the same.

(c) ~~the department becomes aware that~~ the enrollee is a beneficiary of other creditable health insurance;

(d) remains the same.

(e) ~~upon voluntary disenrollment of the CHIP~~ the enrollee wishes to disenroll;

(f) remains the same.

(g) ~~the department becomes aware that~~ the applicant has moved without providing a new address and CHIP is unable to locate the applicant; or

(h) ~~when~~ a completed renewal application has not been received by the department.

(3) remains the same.

(4) A parent or guardian is liable to the department and the department may collect from the parent or guardian the amount of actual ~~premiums or~~ payments to the TPA contractor or ~~both~~ to providers for any benefits furnished to the enrollee because of an intentional misrepresentation or a failure to give notice of changes as required by this subchapter.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.209 ELIGIBILITY VERIFICATION REVIEWS (1) Income verification is not required to be attached to the application.

~~(1)~~ (2) To verify the eligibility determination, a random sample of families will be required to participate in an eligibility verification review and provide documentation to verify the income information ~~as stated~~ they provided on their applications.

(a) A family will have at least 14 days from the date of the written request by the department to submit the required income documentation.

(b) If a family does not provide documentation, CHIP-eligible applicants will be taken off the CHIP waiting list or disenrolled, as appropriate.

(c) A family who provides documentation after ~~14 days~~ they have been disenrolled or removed from the waiting list will have the application reprocessed as if it is a new application.

(2) through (3) remain the same but are renumbered (3) through (4).

AUTH: 53-4-1009, MCA
IMP: 53-4-1004, MCA

37.79.301 COVERED BENEFITS (1) The following services, if medically necessary, are covered benefits: ~~An insurer must provide medically necessary benefits including~~

(a) inpatient ~~and~~ hospital;

(b) outpatient hospital~~,~~;

(c) physician~~,~~;
(d) advanced practice registered nursing~~,~~;
(e) prescription drugs~~,~~;
(f) laboratory and radiology~~,~~;
(g) mental health~~,~~;
(h) chemical dependency~~,~~;
(i) vision~~,~~;
(j) audiology~~,~~; and
(k) medical dental benefits as provided in this subchapter unless specific limitations to benefit coverage are noted. A service may be subject to prior authorization requirements.

(2) remains the same.

(3) Emergency services, including urgent care and emergency room screening to determine if a medical emergency exists, shall be available 24 hours per day, seven days per week. In emergency situations, no ~~pre-authorization~~ prior authorization is required to provide necessary medical care and enrollees may seek care from nonparticipating providers. ~~The insurer~~ Prior authorization may~~, however, require prior authorization~~ be required for any needed follow-up care.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.302 COVERAGE LIMITATIONS (1) The lifetime maximum benefit coverage is one million dollars per enrollee ~~per enrollee insurer~~.

(2) Pre-existing conditions of each enrollee are covered as of the effective date of enrollment if the condition would be otherwise covered except in the following conditions:

~~(a) an enrollee, hospitalized prior to the date of enrollment, who remains in the hospital on the effective date of initial CHIP coverage shall not be covered for inpatient benefits for such hospitalization only. Upon discharge, the enrollee shall become eligible for benefits for any subsequent inpatient hospitalizations. This exclusion shall not apply to enrollees who are renewing their CHIP enrollment.~~

(3) ~~The insurer shall provide c~~Covered benefits shall be provided to an enrollee who is receiving inpatient hospital benefits up to and including the 11th day after the effective date of losing CHIP benefits.

(4) A newborn of a CHIP enrollee shall have all medically necessary benefits covered by the ~~insurer~~ CHIP program for 31 days after the newborn's date of live birth. Coverage for the newborn shall begin the day of live birth, without regard to whether the newborn is hospitalized on the date of coverage.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.303 BENEFITS NOT COVERED (1) In addition to any exclusions noted elsewhere in these rules, the following services are not covered benefits:

(a) through (n) remain the same.

(o) ~~ambulance or other~~ any medical transportation;

(p) ambulance services;

~~(p)~~ (q) abortions which are not performed to save the life of the mother or to terminate a pregnancy which is the result of an act of rape or incest;

~~(q)~~ (r) in vitro fertilization, gamete or zygote intra fallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, or fertility enhancing treatment beyond diagnosis;

~~(r)~~ (s) acupressure;

~~(s)~~ (t) contraceptives, for the purpose of birth control;

~~(t)~~ (u) temporomandibular joint (TMJ) treatment;

~~(u)~~ (v) hypnosis;

~~(v)~~ (w) durable medical equipment; and

~~(w) mental health therapy when the enrollee is not present; and~~

(x) any treatment which is not medically necessary.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.312 PRESCRIPTION DRUG BENEFITS (1) through (4) remain the same.

(5) The ~~insurer~~ CHIP program shall use the Medicaid formulary if ~~it~~ the program chooses to employ a formulary.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.316 MENTAL HEALTH BENEFITS (1) Mental health benefits include:

(a) inpatient services furnished by public or private licensed and qualified ~~practioners~~ practitioners in a hospital, including a state-operated mental hospital, a residential service, or a partial hospitalization program; and

(b) remains the same.

(2) Mental health benefits are limited to:

(a) remains the same.

(b) partial hospitalization benefits which are exchanged for inpatient days at a rate of two partial treatment days for one inpatient day; ~~or~~ and

(c) remains the same.

(3) through (3)(g) remain the same.

(4) Additional mental health benefits are available for children with a serious emotional disturbance. These additional services are limited and may include:

(a) additional therapeutic group home care, including room and board;

(b) additional office visits for enrollee and/or family;

(c) therapeutic family care (moderate level);

(d) day treatment;

(e) community based psychiatric rehabilitation and support; and

(f) respite care.

(4) remains the same but is renumbered (5).

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.326 DENTAL BENEFITS (1) through (4) remain the same.

(5) Enrollees with significant dental needs beyond those covered in the basic dental plan may, with prior authorization, receive additional services through the CHIP Extended Dental Plan (EDP).

(a) A CHIP enrollee determined eligible for extended dental benefits may receive additional services in the benefit year. The maximum EDP payment to all dental providers for an enrollee's additional dental services is $1000 per benefit year.

(b) The type of services covered by the EDP are the same type of services covered under the basic dental plan.

(c) The maximum basic and EDP payments combined is $1350 ($350 basic plan and $1000 EDP) for a benefit year.

(5) and (6) remain the same but are renumbered (6) and (7).

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.501 COST SHARING PROVISIONS (1) Except as provided in (2) and (3), the parent or guardian of each CHIP enrollee whose family income is greater than 100% of the federal poverty level must pay to the provider of service the following copayments not to exceed the cost of service:

(a) through (d) remain the same.

(e) $3 per prescription or refill of an outpatient generic drug; ~~and~~

(f) remains the same.

(g) $6 per mail order prescription or refill of an outpatient generic drug (90 day supply); and

(h) $10 per mail order prescription or refill of an outpatient brand name drug (90 day supply).

(2) No copayment shall apply to:

(a) and (b) remain the same.

(c) dental, pathology, radiology, or anesthesiology services; ~~or~~

(d) families with at least one enrollee who is a Native American Indian or Native Alaskan~~.~~; or

(e) extended mental health services for children with a serious emotional disturbance as stated in ARM 37.79.316(4).

(3) remains the same.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.503 ENROLLMENT ~~WITH AN INSURER~~ ~~(1) Applicants eligible for CHIP must enroll with an insurer under contract with the department.~~

~~(2) When more than one insurer contracts with the department to provide services in the area in which a family lives, the family may request enrollment with a~~

~~particular insurer.~~

~~(a) If the family fails to choose an insurer, the department may assign an insurer.~~

~~(3) All eligible CHIP family members must enroll with the same insurer.~~

~~(4)~~ (1) ~~An insurer must~~ The CHIP program will accept without restriction eligible applicants in the order in which they are received for enrollment until the ~~insurer's~~ maximum enrollment~~, if any, under the contract~~ is reached, at which time eligible applicants will be put on a waiting list and will be enrolled when spaces become available. Applicants come off the waiting list and are enrolled based on the date they were determined eligible.

(5) through (5)(b) remain the same but are renumbered (2) through (2)(b).

~~(6)~~ (3) The ~~insurer must~~ CHIP program will:

(a) provide each enrollee with a handbook of information about CHIP including a summary of benefits; and

(b) issue an appropriate identification card to each enrollee.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, 53-4-1007, MCA

37.79.505 DISENROLLMENT ~~WITH AN INSURER~~ (1) Participation in CHIP is voluntary and an enrollee may withdraw from the program at any time.

~~(2) An enrollee, parent or guardian may request, without good cause, disenrollment from one insurer and enrollment with another insurer annually.~~

~~(3) An insurer, based on good cause, may request that the department disenroll an enrollee. The request with the reason for the request must be in writing.~~

(a) CHIP benefits may be terminated for good cause if the enrollee, parent, or guardian has violated rules adopted by the Montana Commissioner of Insurance for enrollment with an insurer.

(b) Good cause shall be defined as provided in Montana insurance law and rules and does not include an adverse change in health status.

~~(4)~~ (2) Disenrollment takes effect, at the earliest, the first day of the month after the department receives the request for disenrollment, but no later than the first day of the second calendar month after the request for disenrollment is received. The enrollee remains enrolled ~~with the insurer~~ in CHIP and the ~~insurer~~ CHIP program is responsible for benefits covered under the contract until the effective date of disenrollment, which is always the first day of a month.

~~(5)~~ (3) The department will disenroll an enrollee if the enrollee becomes ineligible. ~~from a particular insurer if:~~

~~(a) the contract between the department and the insurer is terminated;~~

~~(b) the enrollee permanently moves outside the geographic area served by the insurer and:~~

~~(i) no other insurer can provide care through participating providers; and~~

~~(ii) the enrollee, parent or guardian does not agree to travel to the nearest participating provider for medical care except in the instances noted in ARM 37.79.605; or~~

~~(c) the enrollee becomes ineligible for CHIP.~~

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.601 CONTRACTS FOR TPA BENEFITS (1) The department may enter into a contract with an insurer entity with a certificate of authority issued by the Montana Commissioner of Insurance to provide any of the benefits third party administration specified in these rules.

(2) An insurer entering into a contract with the department for the delivery of benefits assumes the risk that the costs of performance may exceed the consideration available through the premium.

(3) An insurer must provide the department with documented assurances to show that the insurer is not likely to become insolvent. This requirement may be satisfied by documenting compliance with rules adopted by the commissioner of insurance.

(4) (2) An insurer A third party administrator may not in any manner hold an enrollee, parent, or guardian responsible for the debts of the insurer third party administrator.

(5) The department may contract with one or more insurers in an enrollment area.

(6) and (7) remain the same but are renumbered (3) and (4).

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.602 PROVISION OF BENEFITS (1) An insurer The CHIP program may impose the following requirements in the provision of benefits:

(a) remains the same.

(b) preauthorization prior authorization for benefits other than emergency services;

(c) and (d) remain the same.

(2) An enrollee must use an insurer's the CHIP program's or the TPA's participating providers unless:

(a) the insurer CHIP program authorizes a nonparticipating provider to provide a service; or

(b) remains the same.

(3) An insurer The TPA and its participating providers must provide covered benefits as listed in this subchapter to enrollees in the same manner as those benefits are provided to non-CHIP members in the insurance plan.

(4) An insurer may at its discretion offer benefits beyond the scope of CHIP benefits defined in this subchapter.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.605 PARTICIPATING PROVIDERS (1) An insurer, unless otherwise provided in this rule or Montana law, may select the providers of medical services it

~~deems necessary to meet its contractual obligations with the department.~~

~~(2) An insurer must maintain an adequate network of participating providers to serve enrollees. The insurer must notify the department when providers are deleted from the network.~~

~~(3) An insurer may establish its own enrollment and reimbursement criteria for participating providers.~~

~~(4)~~ (1) The ~~insurer~~ third party administrator must offer to federally qualified health centers (FQHCs), rural health clinics (RHCs), Title X family planning providers, Indian health services providers, tribal health providers, urban Indian centers, migrant health centers, and county public health departments terms and conditions that are at least as favorable as those offered to other providers ~~contract providers, if these entities substantially meet the same access and credentialing criteria as other contract providers and only for geographic areas jointly served by the entities and the insurer~~.

~~(5)~~ (2) ~~Upon written notice by the department, the insurer must~~ The department and the third party administrator will deny payment to ~~exclude from providing benefits to CHIP enrollees~~ a provider who is currently suspended or terminated by the Medicaid or the Medicare program in any state.

(6) and (7) remain the same but are renumbered (3) and (4).

(5) Participating providers may not bill the enrollee, parent, or guardian for any medical care provided beyond the cost sharing provisions outlined in ARM 37.79.501.

~~(8) An insurer may set notification and claim filing time limitations relating to the provision of care by nonparticipating providers. Failure to give notice or file claims within those time limitations, however, does not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.~~

~~(9) A provider has no right to an administrative hearing with the department when the insurer has denied payment for a service provided to an enrollee.~~

~~(10) A provider, in providing benefits under contract with an insurer, is not subject to any requirements or rights provided in this rule.~~

~~(11)~~ (6) ~~An insurer~~ A third party administrator may not prohibit a participating provider from:

(a) discussing a treatment option with an enrollee, parent, or guardian; or

(b) advocating on behalf of an enrollee within the utilization review or grievance processes established by the ~~insurer~~ third party administrator.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.606 REIMBURSEMENT OF ~~INSURERS~~ THE THIRD PARTY ADMINISTRATOR (1) In consideration for all services rendered by ~~an insurer~~ a third party administrator under a contract with the department, the ~~insurer~~ third party administrator will receive ~~a~~ payment ~~each month for each enrollee~~ for services provided as agreed in the contract. ~~This payment is the premium. Unless otherwise provided in this rule, the premium represents the total obligation of the department with respect to the costs of medical care and benefits provided to each enrollee~~

~~under the contract. Payment of the premium is considered to be payment in full and the insurer may not bill the enrollee, parent, or guardian, nor let its providers bill the enrollee, parent, or guardian for any medical care provided beyond the cost-sharing provisions outlined in ARM 37.79.501.~~

(2) ~~The insurer may retain any savings realized by the insurer from the expenditures for necessary health benefits by the enrolled population totaling less than the premium paid by the department.~~ The third party administrator will receive a monthly administrative fee and weekly claims payment. These payments are considered to be payment in full and the third party administrator may not bill the enrollee, parent, or guardian for any medical care provided beyond the cost-sharing provisions outlined in ARM 37.79.501.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.607 UTILIZATION REVIEW AND QUALITY ASSURANCE (1) The ~~insurer~~ third party administrator shall have adequate staff and procedures to assure that health care provided to enrollees is medically necessary and appropriate.

(2) The ~~insurer~~ third party administrator shall comply with and cooperate in any external quality review that may be implemented by the department or its designee. An external quality review may include participation in the design of the review, collection of data, and making data available to the department or its designee.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

37.79.801 GRIEVANCE AND APPEAL PROCEDURES (1) ~~An insurer~~ A third party administrator must have a written procedure, approved in writing by the department before implementation, for resolution of grievances or complaints brought by enrollees or their parents or guardians either individually or as a class. In a situation requiring urgent care or emergency care, the department may require the ~~insurer~~ third party administrator to expedite resolution of a grievance within a time line established by the department.

(2) Except when CHIP eligibility has been denied, an enrollee, parent, or guardian must exhaust the ~~insurer's~~ third party administrator's grievance procedure before appeal of the matter may be made to the department.

(3) An applicant, parent, or guardian aggrieved by a denial, suspension, or termination of CHIP eligibility or an enrollee, parent, or guardian aggrieved by a final grievance decision of ~~an insurer~~ a third party administrator, including but not limited to a reduction or denial of benefits, may request a fair hearing in accordance with ARM 37.5.304, 37.5.313, 37.5.322, 37.5.325, 37.5.328, 37.5.334, and 37.5.337. ~~The provisions of ARM 37.5.305 do not apply to such hearings.~~

(4) If a written request for hearing is not received by the department within 90 days after the date a notice of adverse action is mailed by the department or a final grievance decision is mailed by ~~an insurer~~ a third party administrator, the hearing officer may deny a hearing as provided in ARM 37.5.313.

(5) remains the same.
AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

5. ARM 37.79.504, RIGHT TO CHOOSE PRIMARY CARE PROVIDER, as proposed to be repealed is on page 37-17686 of the Administrative Rules of Montana.

AUTH: 53-4-1009, MCA
IMP: 53-4-1003, MCA

6. The Department of Public Health and Human Services (DPHHS) Children's Health Insurance Plan (CHIP) Bureau is proposing changes to CHIP's Administrative Rules. CHIP is a state and federally funded program to provide health care to children up to the age of 19 with family income and assets greater than the amount that qualifies for Medicaid benefits but less than or equal to 175% of the federal poverty level.

These rule changes are necessary to edit outdated language, to correctly state how custodial parent income is measured and to state program administration changes that were implemented when the CHIP program changed from a fully-insured health plan to a self-insured plan with a contracted third party administrator (TPA).

RULE I

New Rule I is being proposed to allow for electronic applications and signatures. Increased use of internet and computer based applications is efficient and cost effective.

ARM 37.79.102

The proposed amendments to this rule clarify the definition of ambulance based medical services. The current rule language was subject to various interpretations by enrollees and providers. The proposed amendment also updates the federal poverty level (FPL) to the current level published in 2007. Funding for extended mental health benefits for children with SED was appropriated in House Bill 2 by the 2005 Legislature. The amendment to the definition of SED is necessary to correctly state the change required by law, which was effective March 1, 2006. CHIP began providing the benefit March 1, 2006.

On October 1, 2006 DPHHS began to self-administer the CHIP program and contracted with Blue Cross Blue Shield of Montana for TPA services. Due to this change, a definition for third party administrator (TPA) is being added. The definitions of "family", "earned income", and "family income" are being revised to be consistent with the changes to ARM 37.79.201.

ARM 37.79.201

On July 1, 2007 legislation became effective changing the eligibility requirements for CHIP from 150% of FPL to 175% of FPL. (2007 Laws of Montana, Chapter 490.) The proposed change makes the rule consistent with Montana law.

On March 1, 2006 changes were made to the length of time a child may not have creditable coverage before becoming eligible for enrollment in CHIP. The time period was shortened from three months to one month to reduce the time period during which a child is uninsured.

The proposed amendment also restates what income of a custodial parent is included in determining CHIP eligibility. The department is not changing its current practice; it is only clarifying rule language. The proposed amendment correctly states the current policy that child support received is considered unearned income of the custodial parent. The amendment clarifies the current practice that foster care income is not included in family income for purposes of CHIP eligibility unless the only child or children in the family are living with the family for foster care.

ARM 37.79.206

The proposed amendment clarifies language rule to clearly state that applicants are not always placed on a waiting list for participation in CHIP because a waiting list does not always exist. The prior wording of this rule caused confusion on this point.

ARM 37.79.207

The proposed amendment adds voluntary disenrollment to the list of reasons for CHIP eligibility termination. This amendment is not a change; it correctly states current practice.

ARM 37.79.209

DPHHS does not require income documentation at the time of application. It conducts eligibility verification reviews for a random sample of CHIP eligibility determinations. To make the rule consistent with CHIP process, wording changes are being proposed.

ARM 37.79.302

This proposal removes the requirement that enrollees hospitalized prior to the date of enrollment who remain in the hospital on the effective date of CHIP coverage shall not be covered for that hospitalization. This was a restriction by contract of the former contracted insurer. DPHHS believes it is in the best interest of CHIP enrollees to remove this restriction.

ARM 37.79.303

The intent of the rule regarding the exclusion of ambulance based medical services was vague and difficult to interpret. This proposed rule change includes a definition of ambulance based medical services in ARM 37.79.102 and revises language in the list of excluded benefits.

This amendment also removes the exclusion of mental health therapy when the enrollee is not present. This change permits reimbursement to a CHIP provider for a limited number of visits with parents to discuss mental health issues related to a CHIP enrollee.

ARM 37.79.301, 37.79.312, 37.79.505, 37.79.601, 37.79.602, 37.79.605, 37.79.606, 37.79.607, and 37.79.801

The proposed amendments to these rules state language and program revisions made when the CHIP program changed from a fully-insured contracted insurance plan to a self insured program with a contracted third party administrator (TPA). The program change, which is provided for in 53-4-1007, MCA, was made in October, 2006. The rules are being revised to remove references to contract insurers and delete the description of the process required to enter into contracts for an insurance policy.

ARM 37.79.316

This change is due to legislation for extended mental health benefits for a child with a serious emotional disturbance. The proposed amendment to this rule adds this as a covered benefit. Funding for extended mental health benefits for children with SED was appropriated in House Bill 2 by the 2005 Legislature. We began providing the benefit March 1, 2006.

ARM 37.79.326

On July 1, 2007 legislation became effective adding extended dental benefits to enrollees with significant dental needs. (Session Law 207, Chapter 169.) The proposed amendment to this rule is necessary to make the rule consistent with the change required by law.

ARM 37.79.501

Due to the extended mental health benefit, this proposal lists these benefits as excluded from copayment requirements.

Copayments related to mail-in prescriptions were added to this rule. This is not a change in fees, the copayments related to mail-in prescriptions were missing from the rule.

ARM 37.79.503

The proposed amendment clarifies the process by which eligible children are removed from the waiting list and enrolled in CHIP if a waiting list is in effect. ARM 37.79.504

This rule is being repealed because it is meaningless under the current CHIP program. There are no restrictions or requirements regarding the selection of a provider from among participating providers.

Fiscal effects

The department expects the proposed amendments to positively impact up to 16,000 CHIP enrollees. The total fiscal impact is estimated to be $4.46 million in state fiscal year 2008. $3.48 million would be federal and $.98 million would be state funds.

7. Interested persons may submit comments orally or in writing at the hearing. Written comments may also be submitted to Rhonda Lesofski, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena MT 59604-4210, no later than 5:00 p.m. on November 23, 2007. Comments may also be faxed to (406)444-1970 or e-mailed to dphhslegal@mt.gov. The department maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. To be included on such a list, please notify this same person or complete a request form at the hearing.

8. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of this notice conform to the official version of the notice as printed in the Montana Administrative Register, but advises all concerned persons that, in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. The web site may be unavailable at times, due to system maintenance or technical problems.

9. The bill sponsor notice requirements of 2-4-302, MCA, apply and have been fulfilled. The primary bill sponsors were notified by letter dated July 26, 2007, sent postage prepaid via USPS.

10. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct the hearing.

/s/ Geralyn Driscoll
Rule Reviewer

/s/ John Chappuis for
Director, Public Health and Human Services

Certified to the Secretary of State October 15, 2007.